Park Homes UK Limited

Allerton Park Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 9 and 26 February 2015 and was unannounced. At the last inspection on 2 July 2014 we found three breaches in regulations which related to medicines, complaints and quality assurance. The provider sent us an action plan which told us improvements would be made by 31 December 2014. At this inspection we found some improvements had been made to meet the relevant requirements.

Allerton Park Care Centre provides nursing care for up to 50 people, including some who are living with dementia and some who have mental health needs. There were 46 people living at the home when we visited. Accommodation is provided in two separate units over two floors with lift access between the floors. There is a communal lounge and dining room on each unit as well as toilets and bathroom facilities. A central kitchen and laundry are located on the ground floor.

The home did not have a registered manager. The registered manager left in December 2014 and a new manager has been appointed and they told us they were in the process of applying for registration with the Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Although people told us they felt safe we found people's safety was compromised. There were not always enough staff to meet people's needs and systems used to calculate staffing levels were ineffective. People were not kept safe from harm as although staff were trained in safeguarding, allegations of abuse were not always recognised or reported.

Improvements had been made in the way people's medicines were managed which meant they received them safely and when they needed them. We also found people had access to health care services when they needed them.

Communication systems between staff were poor which meant senior staff were not always aware of what was happening in the home. For example, there were accidents and incidents involving people using the service which the manager did not know about. Chaotic systems meant senior staff were confused about how many people were in the home and which people were subject to Deprivation of Liberty Safeguards (DoLS) authorisations. Quality assurance systems were ineffective and did not support the management of the home in identifying where improvements were needed.

People's care was not always planned or delivered in a way that met their individual needs and preferences. Some staff training was not up-to-date which put people at risk of unsafe or inappropriate care.

People told us they enjoyed the food, although we found choices were limited and mealtimes were poorly organised. There was a lack of meaningful activities for people and, although one or two people enjoyed trips out in the community, for the majority of people there was little stimulation other than the television.

People spoke positively about the staff who they felt were kind and caring. Yet we saw practices that showed a lack of respect for people and compromised their dignity.

The management of complaints had improved and we saw complaints were being recorded, investigated and responded to.

Overall, although we found some improvements had been made with regard to complaints and the management of medicines, there were significant shortfalls in the care and service provided to people and the home's internal quality assurance systems had failed to pick these up. We identified seven breaches in regulations and you can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Although people we spoke with told us they felt safe, we found people were at risk because staff were not always identifying or responding appropriately to allegations or risks of harm.

There were insufficient staff deployed to meet people's need, which meant they were at risk of receiving unsafe and inappropriate care.

People's medicines were managed safely, which meant they received their medicines when they needed them.

Is the service effective?

Inadequate

The service was not effective. Some staff training had not been updated, which meant people were at risk from staff who did not have the skills and knowledge to meet their needs.

Senior staff were not aware of authorised Deprivation of Liberty Safeguards (DoLS) which were in place and were not complying with conditions. This meant people were at risk of not receiving safe and appropriate care.

Although people said they enjoyed the food, choices were limited and organisation was poor which meant delays for some people in receiving their meals.

People's health care needs were met.

Aids and adaptations were not in place to support people living with dementia maintain their independence and find their way around the home.

Is the service caring?

Requires Improvement

The service was not consistently caring. People were complimentary about the staff, however we observed practices which showed a lack of respect for people and undermined their dignity.

Is the service responsive?

Inadequate

The service was not responsive. People's care was not delivered in accordance with their care plans.

There was a lack of meaningful activities for people and social interactions with staff were limited.

Complaints were recorded and dealt with, however the complaints procedure was not provided in an accessible format of people living with dementia.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led. People were not protected because the provider did not have effective systems in place to monitor and assess the quality of the services provided.

The home lacked consistent leadership and communication systems were poor. Managers, nurses and senior staff were not adequately informed and aware of what was happening in the home.

Allerton Park Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 and 26 February 2015 and was unannounced.

On the first day the inspection team consisted of two inspectors, an inspection manager and an expert by experience with expertise in dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day three inspectors carried out the inspection.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority contracts and safeguarding teams and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We usually send the provider a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not send a PIR to the provider before this inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time observing care in the lounge and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We spoke with 13 people who were living in the home, two relatives, nine care staff, two nurses, the cook, the residential unit manager, the manager, the operations manager and one of the directors. We also spoke with a visiting mental health advisor from the Community Mental Health Team and a Community Matron.

We looked at nine people's care records in detail and one to follow up on specific information, five staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms, bathrooms and communal areas.

Inadequate

Is the service safe?

Our findings

We found incidents had occurred which showed people who used the service were not always safe. For example, we found an incident where one person on the nursing unit had locked themselves in their room at night and staff had been unable to gain access as they could not find the key to open the door. Although the person could open their door from inside the room staff were unable to persuade them to do so until 45 minutes later when the person opened the door. This person was living with dementia and had a history of falls. This meant if the person had fallen in their room or if there had been an emergency such as a fire, staff would have been unable to gain access. When we discussed this with the manager they were unaware of the incident as it had not been reported to them. They were also unable to locate the key for this room. We reported this incident to the local authority safeguarding team and the fire authority.

Another person made an allegation of psychological abuse to us and the manager regarding a staff member. Discussions with the manager and one of the directors showed this allegation had been made by the person previously, however, no safeguarding referral had been made and there was no record to show any action had been taken in response to the allegations made. This meant the person's allegation had not been listened to or acted upon to ensure their safety and wellbeing and staff had not acted in accordance with the home's safeguarding policy. We reported this incident to the local authority safeguarding team.

People we spoke with said they felt safe in the home. When we asked what informed this belief one person said, "I just know I am (safe). They wouldn't harm me in here." Another person said, "I couldn't cope at home, they made me feel well here." One person told us that another person's behaviour sometimes caused them a problem. They said they understood the person's actions were driven by their illness and tried to be accommodating. We asked if the staff offered reassurance or checked that people were all right after dealing with behaviour that challenged others. The person said in their experience staff did not.

Staff we spoke with demonstrated an understanding of protecting vulnerable adults. They told us they were aware of how to detect signs of abuse and knew of external agencies they could contact such as the local safeguarding authority and the Care Quality Commission (CQC) if they had any concerns. They were aware of the whistle blowing policy and felt able to raise any concerns with the manager and felt they would be taken seriously. The provider's policy on safeguarding included information on staff's roles and responsibilities, referrals, identification of abuse, prevention of abuse, types of abuse and confidentiality. However, although records we saw showed some safeguarding incidents had been reported to the local authority, our findings showed not all safeguarding incidents had been identified, investigated or reported as required. We found that the registered person had not protected people against the risk of abuse. This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our observations showed there were times when staff were not available to respond to people. For example, at breakfast time we found there were periods of time when no staff were present in the communal areas. We saw one person in the residential unit choking on some food which after a period of coughing they managed to dislodge. No staff were present and the person was calling out, "Where are you, is anybody at home…no. I can't see you. Where are you?"

We were present in another communal area on the nursing unit when a person displayed self-harming behaviour hitting themselves repeatedly on the head, no staff were present. When we sought help from a staff member, although they were kind, they showed a lack of understanding in managing this type of behaviour. We saw care records for another person showed they required one-to-one supervision as they were at high risk of falls. This person's records showed they had sustained six falls in a five week period. During our inspection we saw this person was in the lounge for periods of time and no staff were present. The nurse we spoke with about this said the person did not need one to one supervision and that staff just monitored them by being around wherever the person went. They told us there was always a staff member in the lounges. Our observations showed this was not the case.

The manager told us the staffing levels throughout the day were one nurse and four care assistants on the nursing unit and one senior care assistant and four care assistants on the residential unit, giving a total of 10 staff on duty in the

Inadequate

Is the service safe?

home. These staffing levels were also quoted in the home's statement of purpose. We looked at the duty rotas from 29 December 2014 to 25 January 2015 and found 25 out of 28 days there were less than 10 staff on duty. On 18 shifts during this period there were fewer than eight staff on duty. This placed people at risk of harm as there were insufficient staff to meet their health and welfare needs. We found that the registered person had not provided sufficient staff to meet people's needs. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with and records we saw showed safe recruitment practices were followed. We found recruitment checks, such as criminal record checks from the Disclosure and Barring Service (DBS) and references, were obtained before staff began work. Records showed there were effective systems in place which ensured nurses' registration with the Nursing and Midwifery Council (NMC) was valid and up to date.

At our last inspection in July 2014 we found medicines were not managed safely. At this inspection we found improvements had been made and the regulation was met.

Medicines were stored securely. Fridge temperatures were recorded daily to ensure medicines were being stored at the required temperatures. Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines. We saw that controlled drugs were stored securely and records were accurately maintained.

Medication administration records (MAR) were complete and contained no gaps in signatures. This meant that people received the medication when they needed it. The MARs showed reasons for any medicine not taken and a record was kept to show medicines which had been destroyed. We found stock levels we randomly checked corresponded with the amounts recorded on the MARs.

One person was taking medication prescribed and supplied by the local mental health services. These medicines required regular blood tests to lessen the risk of side-effects developing. Staff understood why the medicine required care in its administration. Two people were prescribed warfarin and the dosage was dependent on the outcome of regular blood tests. We saw a protocol was in place for staff to follow to ensure the blood results were accurately recorded and the correct dose of warfarin administered.

Arrangements for the administration of PRN (when needed) medicines protected people from the unnecessary use of medicines. Records showed circumstances when PRN medicines should be given. The registered nurse demonstrated a good understanding of the protocol. We checked to determine the prescribing and administration of antipsychotic medicines to treat the behavioural symptoms of dementia. We found no evidence that these medicines were being used or prescribed inappropriately. This meant that excessive sedation, accelerated cognitive decline and increased mortality were not a risk factor of people with dementia at the home.

We were told that one person was able to receive their medicines covertly. Records we saw showed these medicines were given within the legal framework as described in the Mental Capacity Act 2005 (MCA). A best interests meeting had taken place with the GP, the manager of the service, a community matron and a pharmacist. Close relatives had been informed the best interest meeting had taken place and a pharmacist had been consulted on a suitable method of covertly administering medicines in food and drink. The person was currently taking their medicine without it being given covertly. This demonstrated that the service was regularly reviewing whether covert administration was still needed and discontinuing the practice when appropriate.

We spoke with one member of care staff about the use of restraint. They were able to describe de-escalation techniques to minimise the use of restraint. They also demonstrated their understanding that restraint should only be used in a way which respected dignity and protected human rights.

Inadequate

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and specifically the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The CQC also monitors services where people's liberties may be restricted under the Mental Health Act (MHA) 1983.

It was difficult to obtain clear information about DoLS as management systems were chaotic. Records we saw and discussions we had with the manager and a registered nurse demonstrated a lack of knowledge of the legal frameworks and confusion about which people in the home the legal restrictions applied to. We were given contradictory information about the number of DoLS authorisations in place and those which had been applied for and we were not able to establish the facts from either the nurse, manager or senior managers present at the inspection. We had to contact the local authority DoLS team during the inspection to determine what DoLS were in place. They confirmed three people had DoLS authorisations and a further two DoLS applications had been made and decisions regarding these had not yet been determined.

We saw for one person with a DoLS authorisation there were five conditions in place. The conditions had been set by the supervisory body who had authorised the DoLS to ensure the authorisation did not impact negatively on their quality of life. We found these were not reflected in the person's care plan or being followed by staff. When we discussed this with the manager they were unaware there were any conditions in place. This meant the person was not receiving the specific care they required as stated in the DoLS.

We asked the manager whether any people were subject to a Community Treatment Order (CTO). CTOs were introduced to the Mental Health Act 1983 by the Mental Health Act 2007. These orders allowed people to be discharged from being detained in hospital into a community setting whilst still being subject to mandatory conditions. Any breach of these conditions can lead to recall into hospital and detention under section 3 of the Mental Health Act 1983. The manager told us one person was subject to a CTO. However, when we looked at this person's care file there was no evidence to show a CTO was in place. When we discussed this again with the director, they confirmed there were no CTOs in place. This demonstrated the manager's lack of knowledge of people's needs and mental health legislation. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw in care files formal written consent was gained. We saw written signed consent giving approval for the provider to share relevant information with other health care professionals. Consent was gained to agree to overtly administer medicines to people, take photographs for identification purposes and to use people's anonymised information for audit purposes.

We spoke with three care staff about the training and support they received. They spoke positively about the training and thought this made them effective in their work. We saw the majority of care staff had achieved the NVQ (National Vocational Qualification) level 2 award and some had progressed to NVQ level 3. Some staff were currently undertaking study leading to the new level 2 Diploma in Health and Social Care as a foundation to progressing to nurse training. Staff had access to a range of policy and procedure guidance about how to carry out their work.

The manager and staff confirmed the induction process was detailed and staff had to complete the process before they worked unsupervised in the home. The induction complied with the Skills for Care Common Induction Standards to ensure staff were given the skills and knowledge to enable them to meet the needs of the people using the service.

Supervision was cascaded through the staff team. Staff told us they received supervision at least once every three months and had appraisals and records we saw confirmed this.

We looked at a sample of staff training records and saw mandatory training was provided in areas such as safeguarding vulnerable adults, manual handling, food hygiene, first aid and fire safety. Additional training was provided on more specialist topics such as dementia awareness and challenging behaviour.

However, the training matrix the manager provided us with showed some staff had not received the required updates. For example, the matrix showed fire training and moving and handling were updated annually yet two staff had not

Is the service effective?

received updates since 2013. The operations manager told us safeguarding training was delivered once to staff and there were no planned updates. The training matrix showed 15 staff had not received training since 2013 and for one senior staff member the training had taken place in 2010. This meant staff may not be aware of changes in safeguarding policy guidance. Similarly the training matrix showed DoLS training was only delivered once to staff. We saw four out of five nurses had not received this training and the one nurse who had, received the training in 2012. Eight other staff had not received DoLS training since 2012. This meant staff may be unaware of the legislative changes brought about by the Cheshire West Supreme Court judgement in March 2014 in respect of DoLS. This judgement widened and clarified the definition of deprivation of liberty and therefore had implications for all adult health and social care providers. We found that the registered person had not protected people as staff had not received up-to-date training. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with were positive about the meals and described the food as 'lovely' and 'nice'. One person said, "I can't complain about the food, but they just tell us what we're having and that's it." No one could tell us about any input they had had into the menus, or whether they had been asked about their favourite foods. One person said, "I like curries and things. I only get them occasionally." When we asked one person what would happen if they did not like the food or wanted something different, they said, "The staff will just make an alternative." People told us they could request drinks and snacks whenever they wanted them, and we observed jugs of juice and glasses were available in communal areas.

We observed lunch on both units. On the residential unit most people went to dining tables, with one resident remaining in a high backed chair. The television was left on although most people were not able to see it. There was nothing else to add atmosphere or build a sense of occasion. People did not socialise with one another and staff did not act as a catalyst for this, confining interaction to the task in hand. On the nursing unit, a relative joined people for lunch. We saw staff interacted with people as they served the food and there was some limited conversation between people who used the service.

People were offered a choice of "corned beef hash" or "soup and sandwiches", though staff did not explain the flavour of the soup or the content of the sandwiches. When we asked staff on the nursing unit what the soup was they said it was pea and ham, yet when we spoke with the chef they told us the soup was cream of broccoli. The lack of explanation was extended to the dessert course. One person on the residential unit was given a dessert and asked "What is it?" The staff member replied "Fruit and cream," though did not say what type of fruit this was. People were not given any assistance to make their choices other than by being asked the question; they were not shown plates to assist their comprehension or decision and there were no pictorial menus to facilitate this. People were not given any choice in choosing how much or which components of the meal that they had. Where people chose sandwiches they were not given a choice of how many, what filling or what type of bread either by being asked or being shown. We observed different fillings and both white and brown bread sandwiches on the platter which was kept by the food trolley. We saw people were offered second helpings and a staff member noticed one person had not touched their hot meal and checked whether they would prefer sandwiches, which were provided.

Jugs of juice were available at the tables, however at the end of the meal the people were not offered a hot drink. We spoke with one person who had chosen to eat in their room and two hours after lunch still had a plate of sandwiches. When we asked why they had not eaten them they said, "I asked for a cup of tea which was going to be brought, but it did not arrive." This person told us they usually went to the dining room for breakfast but said, "I missed breakfast because I had a long lie-in." They said staff had not checked on them or offered them breakfast in their room.

Our observations showed people were not always involved or given the information they needed, in a way they could understand, to enable them to make an informed choice about food and drinks available to them. We found that the registered person had not provided people with accessible information to enable them to make an informed choice.This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

People told us they had access to their doctor and said staff would arrange this for them. One person said, "I can see a doctor whenever I want to – but I haven't had to do it for a while."

Records showed people accessed health care services. We saw staff worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. This included GPs, psychiatrists, community mental health nurses, speech and language therapists, dentists and opticians.

Many people at the home were diagnosed with a severe mental health disorder, some were at risk of self-harm, neglected themselves and had a history of having being detained under the Mental Health Act 1983. As such some people's care was coordinated under a Care Programme Approach (CPA). This approach ensures a multidisciplinary involvement in assessing, planning and reviewing people's mental health care needs. We saw some people had their medicines prescribed directly from the local mental health service who monitored the dosage and effects.

We spoke with a community matron who visited the home to review people's medication. The matron told us that they had no immediate concerns about care delivery, however they said their advice was on occasions not adequately communicated to all members of the care team which resulted in inconsistent care.

People told us they were able to find their way around the home. However, we found signage was limited. Although there were pictures to help people identify toilets and bathrooms, people's bedrooms were identified by a number, with only some showing people's names. There was no use of photographs or memory boxes to aid people in orientating themselves. The corridors were confusing in layout and the room numbering did not help. For example, in one corridor room 36 was opposite room 29, and room 28 was concealed behind an internal door which lacked signage to tell anyone where it led. Corridors were bare and lacked tactile elements such as rummage boxes or 'destinations' for people who were walking with purpose. Communal rooms lacked personalisation or items for people to hold, explore or use and offered only the television for stimulus. Access through locked doors was difficult for those with poor dexterity, those in wheelchairs, the visually impaired and people with poor memory spans. Many doors in the home were locked with digital locks with various combinations of codes. On some key-pads the numbers had worn off whilst others were not easily accessible to wheelchair users. This meant people's movement throughout the home was restricted and may for some people amount to restraint or a deprivation of liberty.

One of the lounges on the nursing unit was used as a corridor to transit between parts of the home. We saw staff routinely walked through this area without acknowledging people. One door banged each time it was used and contributed to an already noisy and disconcerting environment with a loud television, people vocalising without receiving attention and noise from other parts of the home. One bedroom was positioned next to the banging door, which meant the noise would have been audible in that room at all times of the day.

We recommend that the service explores the National Institute for Health and Care Excellence (NICE) quality standards for people living with dementia under Quality Standard 30 (QS30: Supporting people to live well with dementia) and Quality Statement 7 (design and adaptation of housing) on how premises can be designed or adapted in a way that helps people with dementia manage their surroundings, retain their independence, and reduce feelings of confusion and anxiety.

Requires Improvement

Is the service caring?

Our findings

People we spoke with described the staff as, "Very good" and "Lovely". One relative told us they were very happy with the care their relative received. They said, "The staff are lovely, very pleasant." People told us staff were approachable and they felt able to raise concerns with them. We asked people whether they thought any concerns would be heard and acted on. One person said, "I can talk to them alright but whether they do anything is another kettle of fish." Another person told us, "The staff are alright – sometimes they listen, other times not." We talked with people about how the staff assisted them in maintaining their independence. One person said, "I'm still quite self-sufficient and the staff respect this. I get help when I need it."

Most people said they were treated with respect by the staff. They said they were addressed by name and that staff routinely knocked before coming into their rooms. We saw staff discreetly adjusted people's clothing on several occasions to preserve their dignity. However, we also observed practices which showed a lack of respect for people and undermined their dignity. We saw one person on the nursing unit at 8.50am who was unshaven and had not had their hair brushed. They told us they had not had a drink yet and when we asked them if they wanted to have a shave they said yes and said, "They (staff) may do it later." When we visited again on the second day we found this person in the same state, unshaven and hair dishevelled. Staff told us the person had been up all night walking around.

We saw one person in the residential unit sitting in an armchair with a table in front of them which had food encrusted around the sides. We asked staff what this person had eaten that morning and they told us, "Biscuits." We pointed out the food on the side of the table and they told us they had a night cleaner who was responsible for the cleaning. They did not take any action to clean the table. We also noted this person's fingernails were dirty.

We observed breakfast was not served until mid-morning which meant some people had a long time to wait for their meal as staff told us they started getting people up at 6am. On the residential unit we saw the night staff had given one person porridge for their breakfast and we saw them scraping an empty bowl. There was porridge all over the table, their cup, their hands and the clothing protector. We brought this to the attention of the residential manager, who made no attempt to clean up the mess or bring the person more porridge. They told us the person would get more porridge when breakfast arrived from the kitchen. We saw this person knocked their glass of juice onto the floor. Staff picked up the glass and refilled it. Over an hour and a half later the person was brought another bowl of porridge which they did not eat as they went to sleep. This person had low body weight and staff missed the opportunity to provide them with food they were enjoying in a timely manner.

We saw another person on the nursing unit was in the lounge when we arrived at 7.30am. This person was given a hot drink but was calling out from 9.15am and when the nurse went to them she said, "I know you're hungry, breakfast's on its way. I'm sorry." This person received their breakfast 40 minutes later at 9.50am.

On the residential unit we saw another person at lunch struggled to eat their soup which had been placed on a low table next to them and as they transferred the soup to their mouth it spilt over the carpet. Cruet sets and place mats were encrusted with food.

On the first day of our inspection in the morning we spent time with people in the residential unit. They had not yet had breakfast and the television was on a shopping channel. We asked about who chose the programme and whether they wanted to watch it. One person said, "We aren't allowed to have the remote control. Someone messed about with it once so it's just put on for us." We did not see people being offered a choice of whether the television was on or any discussion about what they wanted to watch. On the second day we visited we found the same. The television was on in the lounge, we asked one of the staff what programme was on. They changed the channel and put the news on, without asking anyone who was sitting in the lounge. This staff member told us the one person who was watching the television did not like the news. We asked the individual what they liked to watch and they told us, "Westerns."

On the nursing unit we saw one person in a wheelchair in the lounge was positioned close to the door which staff used regularly. The person had fallen asleep and their head was leaning over towards the door. No staff noticed how close the door was to this person's head when they came through it. We raised this with staff who moved the person out of the room although they did not ask first whether the

Requires Improvement

Is the service caring?

person wished to be taken to their room before doing so. We asked why there were no footplates on their wheelchair and staff said because the person liked to propel the chair for themselves. We saw they had no shoes on and staff told us the person had taken them off and hid them but did not take any action to address this.

We saw the handover between the night staff and day staff took place in the lounges on both units, where people who lived in the home were sitting. On another occasion we heard staff discussing people's needs in communal areas which could be heard by other people who were sitting in the room. We saw the office door was open on the nursing unit where people's care records were kept in unlocked filing cabinets and other records containing personal and confidential information were out on the desk. This compromised people's right to privacy and confidentiality. We found that the registered person had not ensured people were treated with dignity and respect. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

We found two people's care records were well recorded and showed social workers, the manager and family members were involved in the care planning process. We spoke with three care staff who demonstrated a good knowledge of people's needs, preferences and past clinical and family histories. These care plans included personal hygiene, behaviour management, social interaction, emotional needs, protection from exploitation and sexuality. One person's care plan provided detailed information to enable staff to manage the person's tendency to intrusive behaviour and we saw one member of staff in particular managing this behaviour very well. We saw charts recorded behaviour that challenged others and occurrences were dated, triggers were noted and details of how the incident was dealt with were recorded.

In contrast we saw examples of care planning and delivery that did not meet people's needs. On the residential unit we saw one person in the lounge sitting on an electrically powered pressure relieving cushion which had not been turned on. We asked the senior care worker about this and they told us the cleaner must have turned it off and they then turned it on. We asked how long this person had been sitting in the chair and were told about 20 minutes. When we looked in the care plan it confirmed this individual needed to sit on a pressure relieving cushion. This meant during that time the risk of damage to this person's skin integrity had increased.

We saw the same person was no wearing any socks or stockings and their legs felt cold. We asked the senior care worker about this and they told us if they put socks on this person they took them off, but if they just had slippers they would keep these on. When we looked in the care plan it stated "X will wear thick socks that go up to their knees. This helps to give protection to their legs." This meant either staff were not following the care plan or that the care plan was not accurate. Although this person was sitting in the residential lounge and had their bedroom on the residential side of the service, we were told by the residential manager they were funded for nursing care. We looked at their care plan and could not establish what nursing care they were receiving. The only nursing input we saw was a nurse administering their medication. We asked the residential manager what nursing care they were receiving and they could not identify anything other than medication.

We saw another person's care records showed they had a pressure ulcer to their heel which was being treated by the district nurses. Advice in the care plan stated to 'completely offload pressure to heel at all times' and to elevate and hang the heel off the cushion when sat in the lounge or chair. We saw this person at various times throughout the inspection and at no point was their foot elevated as directed.

On the nursing unit we saw one person's recent needs assessments showed they were at high risk of developing pressure ulcers, were nutritionally at risk and had lost weight. The records showed this person had a pressure relieving mattress in place as a preventative measure. We saw this person was in bed and the mattress was set at 90kg. The person's weight was last recorded on 4 January 2015 as 50.4kgs. This meant the mattress was not set correctly and therefore would not be working effectively to relieve pressure thus increasing the person's risk of developing a pressure sore.

Another person on the nursing unit had a pressure relieving mattress in place as a preventative measure. We saw this person was in bed and the mattress was set at just below 90kg. The person's weight was last recorded on 10 January 2015 as 47.1kgs. This meant the mattress was not set correctly. This person also had a care plan for pressure damage to their hand which had been caused by finger contractures which meant their nails dug into their skin. The care plan stated the person required a rolled bandage to be placed in their hand and their finger nails to be kept short to prevent skin damage. We saw the person had the rolled bandage in place but their fingernails were very long.

The home's statement of purpose stated the nursing unit provides specialist nursing care for people living with dementia, yet we found the needs of some people were not being met. One person who was living with dementia had recently been admitted to the nursing unit. Their pre-admission assessment showed they were at very high risk of falls and required a sensor mat. The care plan for mobility and falls had been reviewed on 21 January 2015 and stated that they continued to require constant one to one supervision but did not require a sensor mat at night as they slept well. This was confirmed by a senior care

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worker we spoke with who said the person did not need a sensor mat as they slept well at night. Yet the daily records for this person showed they had been walking around at night and on two occasions had been moved from their own bedroom upstairs to another bedroom downstairs for 'close observation'.

When we went back on the second day of the inspection the person had been moved into a downstairs bedroom. The staff told us this person's relative had told them the person did not like to go to bed too early and this may be why they were walking around. Yet the daily records showed the person was regularly taken to bed at 10pm and was then up and walking about the unit sometimes going into other people's rooms. Night staff told us the person did not sleep well and was usually up most of the night walking around. The care records showed this person had had six falls since admission to the home, however, there was no effective falls management plan in place other than instructions for one staff member to be with them at all times. Although records showed staff had applied for a DoLS on 13 February 2015, there was no evidence to show that any other professionals had been contacted for advice about managing this person's care needs.

This person had a very detailed life history with photographs which had been provided by their family but this information was not used to inform or direct staff in their approach to the person to help manage their care needs. The care plan was not person centred and did not direct staff in how to support this person. For example, this person's communication plan stated 'staff need to learn X's behaviour and their needs to figure out what X is trying to communicate'.

We found some staff lacked knowledge and understanding of what action to take in an emergency. For example, we asked the nurse in charge on night duty to tell us the procedures they would follow in the event of a fire. The procedures they described were incorrect and would have put people and staff at risk if there was a fire. We saw from the training matrix this staff member had not received any fire training since July 2013. We asked another staff member who had moved from one of the Company's other homes if they had been shown the fire procedures. They said, "No but it's common sense isn't it – we just meet at the front desk." They said they had not been involved in a fire drill since they came to the home. We also reported this to the fire service. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they had a keyworker (a named staff member who works with the person and their family in all aspects of their care). Some people told us they had but they were unable to name them. One person said, "I know I've got one – their name used to be on my door but it's not there now. I don't know what they do." Another person told us how they interacted with their key worker. They said, "I have a key worker, they come and talk to me about anything really. I once told them that I had a headache and they suggested that I go to bed. I thought that was the right thing to say." We spoke with another person and their key worker and they told us about a shopping trip they had arranged for later in the day. We saw the person when they returned from the shopping trip and they were clearly delighted with the outcome of the outing.

In contrast we saw very little interaction or meaningful activity taking place with people on the nursing unit. We saw some people in the lounge were sat alone; others were walking continuously round the unit with little to stimulate or interest them apart from the television. Some people occasionally went outside into the garden to smoke. When staff were in communal areas they tended to congregate together at the table in the lounge or stood observing people rather than engaging with them. We found opportunities for meaningful one-to-one interaction were not fully utilised.

An activity programme was displayed in the home and showed a morning and afternoon activity each day. However, we questioned whether the activities listed were of therapeutic benefit to people or provided anything different from the normal daily routines. For example, sessions included 'afternoon movie', 'TV/Music morning', 'hairdressing', 'newspapers/family time' and 'coffee mornings'. We saw the televisions were on all day in most of the lounges and when we asked staff how 'coffee mornings' differed from the morning drinks round, no one was able to tell us.

On the morning of the first day of the inspection the activity was "Reminiscence", and we observed this in the lounge on the residential unit. The television was left on throughout the session, with people arranged in a semi-circle facing it, which meant the environment did not support what the

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staff member was trying to do. The activities co-ordinator had a range of materials which could have acted as a catalyst for conversation and reminiscence, but they appeared uncertain of how to use them. One person asked, "What am I supposed to do with these?" when they were handed some cue cards. They did not get an explanation. We saw the activities co-ordinator focused on two people at the expense of others and demonstrated a lack of planning as more people may have joined in if there had been a more conducive environment and a group discussion.

During the afternoon we observed a session of musical bingo. Two people were clear with staff they had never played bingo and did not know what to do. Both people were very hard of hearing and were not able to hear the music being played in order to identify the song titles on the bingo cards. Both people repeatedly told staff they could not hear the music and did not know what to do. One person stated, I've never played this; I haven't a clue how to play." They were holding their head in their hands but staff did not pick up on their comments or body language. They became increasingly distressed over the 30 minutes of our observation making comments such as, "I never thought I'd get to be a stupid person……I didn't think I'd ever feel so thick." One staff member commented in response, "Give me a smile," then walked away from the person as they commented that they, "Felt a proper fool." We found that the registered person had not ensured people were treated with dignity and respect. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in July 2014 we found there was not an effective complaints system as complaints were not being recorded or dealt with appropriately. At this inspection we found improvements had been made.

People we spoke with told us they felt they could approach any member of staff if they had a complaint. Relatives also confirmed they felt able to speak with staff. We saw four complaints had been received. Records we saw showed these had been investigated and responses had been sent to the complainant with the outcome of the investigation. We saw the complaints policy was displayed in the home and included timescales for the process as well as information and contact details for other organisations such as the Local Government Ombudsman. However, the complaints policy was not displayed in a format that was accessible for people living with dementia. **We recommend that the service considers the National Institute for Health and Care Excellence (NICE) quality standards for people living with dementia.**

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Our findings

At our last inspection in July 2014 we found the provider did not have effective systems in place to assess and monitor the quality of the service or to identify, assess and manage the risks to people health, safety and welfare. At this inspection we found improvements had not been made and the regulation was not met.

The home did not have a registered manager. The registered manager left in December 2014. A new manager had been appointed and they told us they were in the process of applying for registration with the Commission. The new manager had been in post since 1 December 2014.

Some people we spoke with were familiar with the new manager and we saw one person came to the office and asked for the manager by name. Most people in the residential unit knew the unit manager and said they found them approachable. Although one person said, "The unit manager doesn't like me, they don't bother with me. I don't know what caused it. (Another member of staff) is more helpful, they'll do what I need. I've no problems with anyone else on the staff." However, a visitor said, "(The unit manager) is easy to speak to – they all are."

We found a lack of communication between staff and managers which placed people at risk. For example, we found it difficult to establish how many people were living in the home. The staff member in charge of the residential unit told us there 49 people in the home with 25 people on the residential unit, yet the handover sheet listed 23 people on the residential unit. The nurse told us there were 27 people on the nursing unit. When we asked the manager they initially told us there were 47 people in total, then changed this to 46, with 21 people on the nursing unit and 25 on the residential unit. This meant in the event of a fire or other emergencies staff were not clear how many people were in the building.

The manager told us each bedroom door had a different key to unlock it. We looked with the manager at where the keys were stored. The manager was unable to identify which key was for which bedroom as many keys were not labelled and those that were labelled it was not always clear which room they were for. We looked at the fire risk assessment dated 26 May 2014. There was no reference to bedroom keys and the assessment did not consider the potential risk of service users, who have dementia or mental health needs, locking themselves in their rooms and being unwilling or unable to unlock the door and how staff would access the room if this occurred. This meant potential risks to people's safety in the event of a fire or other emergency had not been fully assessed, identified or managed to ensure people's safety and welfare.

We saw signs displayed in the home which informed people that CCTV was in place. We spoke with the manager and operations manager who were unsure if this was operational and did not know where the cameras were or the monitor. The director told us CCTV had been installed a few years ago on police advice following an attempted break-in. The director confirmed cameras were installed in the corridors but assured us the CCTV was not currently operational. The director was unable to provide us with any evidence to show the installation of CCTV had been done through a consultation process or a policy for the use of this surveillance equipment. We advised the director that prior to any proposed use of this equipment, the Commission's guidance on the use of CCTV must be considered.

We saw minutes from the last relatives and residents meeting which was held in September 2014. The manager told us a further meeting had been planned for 3 December 2014 but the letter to relatives had only been sent five days before the meeting was due to take place and no one had turned up for the meeting. We saw a further letter had been sent out inviting relatives to a meeting on 23 March 2015. We saw evidence that showed staff meetings had been held monthly.

The action plan submitted by the provider following the last inspection had stated the complaints procedure would be available in an accessible format for people living in the home. At this inspection we found this was not in place.

We looked at the monthly accident and incident audits from November 2014 to February 2015. We found information on the audits was incomplete. For example, the audit for January 2015 listed nine accidents/incidents, yet records we reviewed showed six other accidents had occurred to people which were not reflected in the audit. The incident in February 2015 where the person had locked themselves in their bedroom was also not reflected on the audit. We discussed this with the manager who was unaware these events had occurred. This showed us systems in place to identify, assess and manage risks to people were failing and meant people were at risk of harm.

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The accident/incident audits looked solely at actions to be taken on an individual basis to prevent reoccurrence rather than analysing the information collectively to identify recurring themes such as frequency, times, staffing levels and triggers. This meant lessons learnt were not identified or shared to improve practices. These shortfalls had been identified at the previous inspection in July 2014 and we found no improvement at this inspection.

The manager told us people's weights were audited monthly. Yet we saw records were not being analysed properly and it was not always clear what action was being taken in response to weight loss. For example, the audit showed one person was being weighed weekly and they had lost 3kgs over one month yet there was no information to show what action had been taken. Another person had lost over 2kgs in a month and there was no action recorded.

The manager told us there were no audits in place for monitoring pressure ulcers or wounds.

We found the dependency tool which the provider used to calculate the staffing levels was not fit for purpose. We spent time with the residential unit manager who showed us how they had assessed people's dependencies and how this translated into staffing hours. The residential manager was unable to explain how some people's dependencies had been determined and we saw staffing levels were below those calculated as required by the dependency tool.

At the last inspection in July 2014 we found the provider was not notifying us of incidents that had occurred in the home, as legally required. At this inspection, the manager was unable to provide us with evidence to show that notifications had been submitted for the two DoLS authorisations that were in place.

We asked to see the quality monitoring reports from provider visits to the home. We saw reports for December 2014 and January 2015 which had been completed by the manager. The reports were brief and did not contain action plans. The director told us they now employed a quality support staff member who spent four days a week auditing the care and service provided to people in the home. They said this replaced the provider's quality monitoring visit reports. We saw copies of these reports which contained detailed information and included actions to be taken. Similarly comprehensive care plan audits had been completed individually for each person which identified areas for improvement. However, the manager told us they had introduced their own audit paperwork as they found the current audit systems did not provide them with an overall view of the care and service delivery or assist them in identifying where improvements were needed.

Although the provider had systems in place to assess and monitor the quality of service provision we found these were ineffective and had failed to identify and address the serious issues and concerns we identified at this inspection. We found that the registered person had not protected people by ensuring good governance. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered provider had not protected service users from abuse and improper treatment in accordance with this regulation. Regulation 13 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered provider had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to meet the requirements of this Part. Regulation 18 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person had not ensured that persons employed received appropriate training as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)**

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person had not ensured that the care and treatment of service users was appropriate, met their needs, and reflected their preferences. Regulation 9 (1) (a) (b) (c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered provider had not ensured systems and processes were established and operated effectively to assess, monitor and improve the quality and safety of the services provided and to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (1) (2) (a) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered provider had not ensured service users were treated with dignity and respect. Regulation 10 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered provider had provided care or treatment in a way that significantly disregarded the needs of the service user. Regulation 13 (4) (d)**